[Music]

Ivette:
Hello, I'm Ivette Torres and welcome to another edition of the Road to Recovery. Today we'll be talking about preventing and addressing suicide, how everyone can play a role. Joining us in our panel today are: Dr. Polly Gipson, Clinical Assistant Professor at the University of Michigan, Ann Arbor, Michigan; Amelia Lehto, Resource and Crisis Helpline Coordinator - Suicide Prevention at Common Ground, Bloomfield Hills, Michigan; Dr. Jack Jordan, private practice in Pawtucket, Rhode Island, Clinical Consultant for Grief Support Services of the Samaritans, Boston, Mass; Eileen Zeller, Lead Public Health Advisor for Suicide Prevention, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, Rockville, Maryland. Jack, why is it important to address suicide in this country?

Jack:
Suicide is a major public health issue. Not only is there the loss of life of people who die by suicide but as a grief counselor who works with people after a suicide with families and individuals, it leaves a tremendous amount of what a client of mine once called the collateral damage in the wake of the suicide. So it has a tremendous public health impact.

Ivette:
Eileen, how many people more or less die each year by suicide?

Eileen:
So in 2014, which is the latest year that we have the statistics for, 42,700 people died by suicide. We know that's an undercount. We also know that more people die by suicide in this country than die in automobile accidents and that for every one person who dies by homicide, two people die by suicide. Most people don't realize that and I'm guessing that most people who are watching this program in some ways have had their lives touched by suicide.

Ivette:
Amazing. Jack talked a little bit about the impact. Polly, do you want to expand on that? What really is the impact on a family member and on those that are around the individuals who either attempt or have died by suicide?

Polly:
Sure. You know, in some ways it's really immeasurable and what we try to do in our trauma and grief clinic is we really try to take a family approach and talk with each individual member in the family to understand their narrative around the suicide, how they're processing the suicide, what type of traumatic grief reactions they're having so that we can start a dialog within the family because what we know is that oftentimes within one's own family everyone is reacting to and responding to it differently. So it's very important to take that kind of individually

tailored approach and understand how each family member is really processing it and then taking the next step to see how they can support each other.

Jack:
Traditionally, the impact of suicide has been looked at primarily with the immediate family, which makes sense, but we are learning that the impact is much wider. Recent research has suggested that the impact is much wider into the social network beyond just the immediate family even though most of our outreach and services have been for the immediate family. But we really need to think about it, for example, in the workplace setting or in the school setting. The impact can be tremendous but has not been studied very much or attended to in terms of clinical intervention.

Ivette:
And even neighbors I would suspect.

Jack:
Neighbors, friends. What's turning up as a predictor is psychological proximity, people who are close to the deceased are likely to be more impacted regardless of kinship relationship with them.

Ivette:
That's a very nice thought, psychological proximity. Amelia, talk to me about the nexus between substance use disorder, mental health and suicide.

Amelia:
A lot of people are familiar with suicide as it's related to depression. Most people associate the two hand in hand. But that extends beyond with substance use and the rates of suicide go up when substance use is in effect with an individual. It's a concern that they're having and it's often a co-occurring disorder with an underlying mental health condition or a trauma that they've experienced in their life. So it's a very serious concern when somebody is using substances and to look beyond just the bottle that they're drinking out of.

Ivette:
There's also, I suspect, Jack, some issues related to prejudice and discrimination related to suicide both for individuals and loved ones. Do you want to talk a little bit about that?

Jack:
Sure. Historically, particularly in western societies there's been a great deal of stigma since the middle ages really around suicide. In the middle ages, literally the body was taken out and drawn and quartered and shown as a public example but the family was punished also, often run out of the community, weren't allowed to inherit the estate of the deceased. The residuals of that stigma is still alive and well. It's gradually changing I think but survivor families and people who

make attempts face an enormous amount of stigma and mainly ignorance-driven I think.

Eileen:
If I can add to that, and it comes before the issue of even suicide, so if you're struggling with any kind of depression, mental illness, you may be very reluctant to talk about it and so where most people would be willing, for instance, to tell their work colleague I've got a doctor's appointment to check my diabetes or I'm going to see my cardiologist, it's a rare person who is willing and able to say I'm going to see my therapist, I'm going to see my psychiatrist, I'm going to see my psychologist today. There is a feeling of shame about that, that we're really working to make it disappear. And as more and more people who have different kinds of mental illnesses are willing to stand up and say, yeah, I've got depression, yeah, I've got Bi-Polar Disorder, and I'm taking my medications and sometimes it's a struggle but it's all good, that's really helpful. But to not be able to talk about suicide, to not be able to talk about a mental illness means that when you're struggling, it's hard to reach out to friends.

Ivette:
I suspect that, talk a little bit about the fact that there are those that actually carry it out and there are those who attempt. Particularly what you said holds true for those that have already attempted that really need to take stock and analyze their situation to be able to seek help.

Eileen:
It is important that people who have attempted suicide but not died by suicide be able to look forward into the hope of the future and not say—not berate themselves more and say that I couldn't even do this right.

Jack:
Can I just amplify what Eileen has said? In my opinion, the biggest cultural, social cultural barrier we have to suicide prevention is the taboo about talking about both feeling suicidal and talking about psychiatric disorder. That's what stands in the way really of bringing down the suicide rate in the United States is the taboo about being able to talk about it and to seek help for yourself.

Ivette:
But, Jack, how do we break that taboo? What can be done to break that taboo?

Jack:
I think it's changing because people who either have psychiatric disorders and/or people who have been touched by suicide aren't speaking out. There's a survivor-driven—by survivor I mean people who are bereaved by suicide-driven movement and now there's a movement, people who have attempted suicide with that lived experience who are saying this happened to me, I'm a real person and I'm gonna talk about it, I'm not gonna hide it. So to push back against that

attempt to—the shame really that goes along with this, it's a huge barrier to changing things and bringing down suicide rates. We also need more resources.

Ivette:
And within the individual, who is promoting that change? How do you get that individual to really reflect? Is it family? Are there professionals that can weigh in?

Jack:
The support—both has to come from inside the person and there has to be support. Families can have a tremendous role in encouraging people to get help following through with them about it, getting help as a family. There are a lot of different ways to do this but it's a team effort. It really is a cultural agreement that we're gonna do this differently and look at this differently.

Polly:
May I add an example? So for instance, the American Association of Suicidology, the attempt survivors have joined and they are having a community within this organization and helping as to really think about ways for them to have their voices heard, to share their lived experience, and that's just in terms of the cultural change, that's one example of how this has happened.

Ivette:
That's excellent. I want to come back to you but right now we have to take a break and we'll be right back.

[Music]

Female VO:
By facing our mental and substance use disorders, recovery begins and we are empowered to speak our truth. Join the Voices for Recovery: Speak up, reach out.

Male VO:
For information on mental and substance use disorders, including prevention and treatment referral, call 1-800-662-HELP. Brought to you by the U.S. Department of Health and Human Services.

[Music]

Kana:
SAMHSA takes a very active role in suicide prevention. SAMHSA sponsors the National Suicide Prevention Lifeline at 1-800-273-TALK, 1-800-273-8255. This Lifeline connects people to a skilled, trained counselor at a local crisis center, anytime. This counselor will listen to your problems and tell you about mental health services in your area. Calls are free and confidential, and the service is

bilingual- Spanish and English and for those who are deaf or hard of hearing. In 2014, more than 1.5 million people received help by calling the National Suicide Prevention Lifeline. To help providers address suicide, SAMHSA has developed the Suicide Safe mobile app. This app gives providers education and support resources to assess patients' risk of suicide, communicate effectively with patients and families, determine appropriate next steps, and make referrals to treatment and community resources. SAMHSA also funds the Suicide Prevention Resource Center, which promotes a public health approach to suicide prevention and has a library of resources. SAMHSA resources for suicide prevention include: the National Suicide Prevention Lifeline wallet card, the Suicide Assessment Five-step Evaluation and Triage or SAFE-T Pocket card for clinicians, and Treatment Improvement Protocol 50: Addressing suicidal thoughts and behaviors in substance abuse treatment.

[Music]

[Drumming]

Female VO:
Staying on course without support is tough. With help from family and community, you get valuable support for recovery from a mental or substance use disorder. Join the voices for recovery, visible, vocal, valuable!

Male VO:
For confidential information on mental and substance use disorders, including prevention and treatment referral for you or someone you know, call 1-800-662-HELP. Brought to you by the U.S. Department of Health and Human Services.

Ivette:
Welcome back. Polly, I want to talk a little bit more about what you were mentioning about the association where people can get access to some resources and what exactly should individuals who call or access that organization should expect.

Polly:
Sure. Well, I was just highlighting the American Association of Suicidology as once such example. So what we know is it's important for people who are in the community and so in this case attempt survivors to have a voice and to be able to join together with their own community of attempt survivors. And so within AAS there is a division now for attempt survivors and I think that's very important so that it's not just this perception of researchers or clinicians or even crisis line workers that have all the answers but that we are talking with them about their lived experience and we're collaborating and thinking together about how to prevent suicides.

Ivette:
Very good. Amelia, you have some lived experience. Do you want to share that with us?

Amelia:
Yeah. I am one of the nine million people in the U.S. who has lived with suicidal thoughts. When I was 13 years old, I lost my best friend to suicide. I'd experienced some sexual abuse trauma in my past so it all came together and I thought of killing myself. I didn't know how to handle the pain, I didn't know how to cope and I reached out to my mom and we sought therapy and I saw this wonderful therapist and he took me seriously and really heard my narrative, as Polly shared, and we decided I would be inpatient to keep myself safe and really build on my skills in a child psychiatric unit. And I stayed there for a couple of weeks and then did outpatient my 8th grade year and that continued on throughout high school up until adulthood when I really pulled all of my personal resources, my professional resources and really found my place in the community working with other people through volunteering at a crisis line, and now I work professionally in the field.

Ivette:
Very good. Jack, what are some of the research-based practices to support people who have attempted suicide?

Jack:
Well, I'll say a couple of things but I may want to defer to somebody else because I'm primarily a grief counselor, grief therapist, after suicide happens. There are evidenced-based programs now that range from peer-to-peer kinds of support that I think Polly was referring to. Probably the best study has been cognitive behavioral treatments but there's a new approach called the CAMS approach, Collaborative Assessment and Management of Suicidality from David Jobes which is a more relationally-focused treatment approach. So there are treatment approaches that are being studied; not nearly enough. There's been kind of a taboo about researching suicidality because universities proving studies on this get a little skittish about what happens if somebody kills themself during the trial. But we can't get better at helping people who are suicidal if we don't do the research.

Ivette:
Well, you know a lot even though you're a grief counselor, Jack. Eileen, let's go to you and expand on that.

Eileen:
I would love to do that. For someone who says he doesn't know a lot, you know a lot. There's a third model also that has quite a bit of evidence called Dialectical Behavioral Therapy with Marhsall Lanahan.

Ivette:
We need to really explain what that is and how one can access that.

Eileen:
And I am not the person to do that because I am not a clinician, so I don't know if you've ever used DBT before.

Polly:
I have and I can talk some about that. I think what I want to say before I give those details is just that it is important if someone thinks that they need to see a mental health professional to do so and to get a comprehensive evaluation. So as we're all mentioning, these are treatments that are provided by licensed professionals and so it is important for families and those that may love someone that they think might be suicidal to help them to take that step. And then once you get an evaluation, there will be recommendations and they might recommend the DBT or the Dialectical Behavioral Therapy which is a psychotherapeutic approach that really helps people to—to help with emotion regulation. It helps people to have—Dr. Lanahan talks about radical acceptance. It's very important to sit with people's pain and understand the reasons for dying but trained clinicians know how to do this. In terms of the CBT strategies, the Cognitive Behavioral Therapy, there's a lot of focus there on coping skills, problem solving, a lot of emphasis on implementation of a safety plan and really walk—I work with youth—and really walking with youth through the various steps, the various strategies of what you can do when you're triggered, when you're experiencing suicidal thoughts, urges. So I think it's just important for people to have an understanding, as you mentioned, that there are evidence-based practices but to really seek a mental health evaluation.

Jack:
Can I add something? I completely agree with what everyone has said here. I also think it needs to be said though that the training of clinicians in working with suicidality leaves a lot to be desired and there really is an effort going on now to make sure that mental health professionals are adequately trained to work with someone who is suicidal. That effort is underway but we have a long way to go and I want to encourage people who are looking for mental health treatment that they don't have to stay with the first person they see, and you can't assume that everybody you see has adequate training. Don't be afraid to ask about what's your experience working with someone who is very depressed or suicidal, what do you recommend, what have you found that has worked, and have you had training in it?

Ivette:
And I bet that's very critical, Amelia, in terms of calling a helpline. How are individuals in the helpline trained and what can people expect when they call a helpline?

Amelia:
Yes, it is crucial to know that you can question your mental healthcare providers and know that it's okay to ask them a series of questions to know that their values line up with yours and what you're looking for in your treatment plans. When callers come to crisis lines, they call us and are looking for immediate care in their acute crisis state and crisis trainings are very diverse across the country. We have a wonderful accreditation programs through American Association of Suicidology to Contact USA, for example, and for my organization, Common Ground, we do a 90-hour training for our crisis interventionists and we provide interpersonal relations trainings throughout so people really get hands on with their training. We pull on past traumas that have healed to give real life practice rather than a role play, here's an assignment, let's practice that. It's real from their own personal experiences. I really enjoy the narratives that people bring is really important to share that. So we pull on those strengths of individuals and we really enhance the compassion and the empathy that people are looking for when they are reaching out to a crisis line to have somebody really hear what you have to say and really value that and share what resources are available or help validate and build up the resilience in the person because it's hard to reach out, it's hard to ask for help, but we're there.

Ivette:
Very good. Eileen, SAMSHA has a tremendous amount of resources right now related to suicide prevention and I know one of them in particular, a Journey Towards Health and Hope is one that is very attractive to individuals looking for more information.

Eileen:
Right. So Journey Toward Health and Hope is a booklet written for people who have attempted suicide, especially those who have really just attempted suicide. What do they do, where do they go, and the purpose of the manual is to give them hope, to help them keep themselves safe, and to help them understand that they are not alone, that other people have gone through this before, they've come out stronger, healthier, happier. It's a wonderful manual and you can download it on the SAMSHA website.

Ivette:
And what other resources does SAMSHA have?

Eileen:
Many, many. So one that everyone needs to know about is the National Suicide Prevention Lifeline that is actually a network of more than 160 different independently funded crisis lines of which yours is one, and you can call 24/7. You will be directed to the crisis center that is closest to you geographically and you will talk to a trained counselor about anything you like.

Ivette:
Are there referrals that are made?

Eileen:
Yes. So they will talk to you about whatever you're feeling, if you're in crisis, if there's someone else that you'd like them to talk with and they will refer you to someone local.

Jack:
Eileen, do you want to mention the Veterans line also?

Eileen:
Absolutely. When you call the National Suicide Prevention Lifeline, there is a greeting and it tells you that if you are a Veteran or military service member or calling about one, to press 1 and you will be connected to the Veterans crisis line in Canandaigua, New York.

Ivette:
I want to come back to that because I think there's room for us to talk about specific issues related to different groups. We'll be right back.

[Music]

Ashley:
American Indian Health and Family Services was founded in 1978. Within the 7 county service area we actually serve about 47,000 Native Americans potentially according to the last census. We have our medical services which is our basic family practice; we also have our behavioral health which does our outpatient mental health and substance abuse treatment and we also have a lot of other ancillary services like exercise and nutrition, we have our youth program, a lot of cultural programs and other things to really complement our medical and behavioral health services. Our Sacred Bundle project is kind of twofold project addressing suicide in our community and preventing suicide from increasing in our community through trainings and training gatekeepers to provide services as well as reaching out and doing our own screenings as well.

Karen:
What we know here in the US is the rate of deaths, the number of suicides per 100,000 population for Native Americans ages 8-24 is the highest racial ethnic group that there is in the country. The Sacred Bundle program is really unique in that we are truly a community based project because we are located in an urban area and we see Native Americans from probably 30 different tribes who have settled in this area, and need to be hooked back into their culture, in that way we are serving them by providing culture to them, traditions, things they might have missed out on.

Ashley:
We really value that integration of culture into care and following the medicine wheel and the importance of addressing the spiritual and cultural needs of an individual to promote healing and to keep them in the right place with their minds and their bodies at the same time.

Karen:
We provide outreach in terms of making sure people know that culturally appropriate healthcare and behavioral healthcare are available here at the agency, we also do screenings of youth ages 10-24, we screen for depression, thoughts of suicide and substance use. We offer counseling services and other referral services for youth who might need that.

Ashley:
But we are also training gatekeepers in the community and I think that's a really big aspect of our program. We realize there's only so many of us and that we truly can't reach those 47,000 natives in the area and so we really have to rely on the community to provide these services and we have to give them the tools that they need to help us.

Elizabeth:
Landing here at the agency I found this wholeness because the approach is not just to the emotional or behavioral but the physical and the spiritual and I think that is treating or attending to the whole person and that is not something that… it's very unique, you're not going to find that anywhere else.

Karen:
The work that we do sometimes feels like we can't do enough but we're seeing communities now take this on and really want to make a change and that makes it all worthwhile.

[Music]

Amelia:
So when I was 13 years old, I found out that my best friend had killed herself and it rocked my world. I can tell you where I was standing when I felt my world shift and it's really impacted the rest of my life. It's come full circle. When I was 13, I went to my friend's house, gave my cupcakes because we were having a party and my world changed from the fallout from my loss. And I had experienced some sexual abuse when I was younger and that didn't really come out until I sought inpatient treatment after seeing a therapist, and him and my mother and me agreeing that that was probably the safest place for me at that time because I didn't know where I fit in the world. So for individuals who have come in contact with those that have attempted or have lived experience with suicide, be supportive. Be a listening ear. Let them drive the car. Be the navigator getting them to what's gonna help them most at the time whether that be professional

care or personal or spiritual, you know, really support them in that moment, and no need to overreact. They're overreacting themselves trying to comprehend what's just happened in their lives. Be as supportive as possible. My life experiences have come together in a really powerful way. A lot of good has come out of the really bad in my life and helping others really helps myself.

[Music]

Male VO:
For those with mental or substance use disorders, what does recovery look like? It's a transformation, it's a supporting hand, it's new beginnings. When does recovery start? It starts when you ask for help and support.

Female VO:
For information on mental and substance use disorders, including prevention and treatment referral, call 1-800-662-HELP. Brought to you by the U.S. Department of Health and Human Services.

[Music]

Male VO:
For more information on ***National Recovery Month***, to find out how to get involved or to locate an event near you, visit the ***Recovery Month*** website at recoverymonth.gov.

Ivette:
Welcome back. Polly, you work with youth. I want to come back to Eileen to talk about the Vets but you work with a youth population. Is that a group that is more highly vulnerable regarding this issue?

Polly:
Yes, it is. So unfortunately we know that adolescence in and of itself can be a developmental period that can place someone at higher risk because if you think about it in adolescence there's so much change and transition and there's just a lot going on. But within adolescence we also know that there are special populations. So, for instance, LGBTQ, so that is youth who maybe identify as lesbian, gay, questioning or even transgender, that that is a group within adolescence that also can be at elevated risk for suicide. But the one thing that I want to make sure that our viewers understand is suicide is very sneaky and elusive and so we don't want to give the impression that there's one answer or there's one risk factor. There's a myriad of risk factors and we're trying from a research perspective to understand them and to understand how they may work in combination. So what I really want people to know is just to be on the lookout for changes. I want people to, if they have a concern, to ask a young person—it's okay to ask a young person how they're doing and to be prepared to listen to whatever they may say to you.

Ivette:
I do want to stay with this issue of the youth because I was speaking to one of our SAMSHA National Advisory Council members, she's a person of Native origin and she was mentioning that among the reservations now there's a tremendous amount. Do you want to speak to that and address what some of the underlying causes may be and what can be done?

Polly:
Yes. So that is also another special consideration, another group within adolescence that we know can be at elevated risk. And, again, there's a lot of research being done. Some of it has to do with their history and so it is important to understand a group, in this case Native Americans, their history and how that might play into a risk factor of understanding cultural losses, cultural meaning. There's a lot of factors there that people are focusing on from a research perspective but I'm glad that we're learning that that is a group that is at elevated risk, but it's also imperative among us to really understand that there are maybe specific cultural reasons that places that group at risk. So that's important because as we think about prevention and intervention strategies, we need to be able to reach people in a way that they can receive the message.

Ivette:
Very good. Eileen, you wanted to say?

Eileen:
I did. So about 5% of the people who die by suicide in this country are under the age of 24. If you look at where the bulk of suicides are, it is in people of midlife, especially men. So between the ages of 35 to 64, which is what we call working aged men, is where most of our suicides are today.

Ivette:
Let's go back to the Veterans group because you mentioned a resource but you really didn't talk about the idiosyncrasies of what makes them so vulnerable.

Eileen:
Sure. And, again, we're doing a lot of research on what makes Veterans and service members more vulnerable. The Department of Defense and the Department of Veterans Affairs are both doing research on it.

Ivette:
From what you know though, can you share?

Eileen:
Absolutely. So what you have is that this population is primarily men who are at highest risk. They have access to lethal means, which is really important and something that we haven't touched upon yet. So you can be thinking seriously of

suicide and you can be considering it, you can have a plan, but if you don't actually have something that you can do it with, then you're not going to die by suicide. And the more lethal the means are, the means that you want to use, the worse it's going to be. So God forbid, if you hang yourself or take medication, hopefully someone is going to find you before you die. We all hope that that happens. If you—once you have a weapon and you shoot that, nobody can take back the bullet, and so Veterans and service members all know how to use weapons. Many of them have weapons at home. It's a part of their lives and we don't want to take that away from people but in the same way that we would want to take keys away from someone who is drunk and shouldn't be driving, we would like to be able to have the weapon given to a close friend whom they can trust until they're no longer suicidal.

Ivette:
Amelia, we also have the fact that many members of the military, active and when they're no longer active members, also suffer from posttraumatic stress, and I suspect that you get many calls sometimes from said individuals.

Amelia:
Yeah. Posttraumatic stress can be a huge factor for individuals. It overwhelms the coping systems, what they've seen, what they've experienced, what they've heard, what they've felt, and it is hard for a person internally to process what has happened within them. So we encourage those to reach out to seek the professional help to find the right fit in your mental healthcare to address those concerns and that's something that we can do on our crisis line, share the local referrals of the specialists that provide it, share the access to community mental healthcare, to see what their eligibility is, helping them obtain access to that care and addressing the real root concerns. And we also know that Veterans, they talk to each other. They are very peer driven, they are very supportive in their experiences and what they've been through and how they view the world, and we refer to many Veteran organizations in our local area and the Veterans Crisis Line does as well. I believe they have peers working on the lines, those that have served in the military and that's what really works.

Ivette:
Excellent. Thank you. Jack, I think Eileen started dealing with the whole issues of means reduction and you brought up some interesting facts during the break.

Jack:
The statistic that I cited for you was that 60%, three out of every five gun-related deaths in America are suicides. They're not people using guns for self-defense or even domestic disputes or even accidental deaths. The main way that people die by guns in America is suicide which is the whole issue of means reduction is crucial to reducing suicide rates. A superb website with information about that is called Means Matter. It's put up by the Harvard School of Public Health and

anyone that's interested in that, looking at the data in a very evidenced-based way I encourage you to go and look at that website.

Eileen:
There's also a wonderful free online class called CALM. It's on the Suicide Prevention Resource Center website which would be helpful to any practitioner.

Jack:
C-a-l-m.

Eileen:
C-a-l-m, right.

Ivette:
Very good. Amelia?

Amelia:
As far as firearms are concerned, many people may own them in their homes but they may not know that there are very easily accessible lock-and-key safes. There's gun locks for guns. Separating the ammunition from the firearm can be a very good tool and as Eileen shared, sharing it with a friend that you feel is safe for keeping, a lot of police departments will hold a weapon if it is asked of them and shared, you know, what's happening and though they may ask for a doctor's note or something of that regard, that the person has taken the next steps to getting care is an option.

Ivette:
Which brings us to another point, Polly. We've talked about people who have the courage and the fortitude to call a crisis help line to get assistance. What particularly in the young people, what clues do parents or caretakers or friends need to know and look out for in order to intervene and work with someone who's thinking of suicide?

Polly:
Yeah, that's a great question. On the SAMSHA website they use an excellent acronym; Is The Path Warm. And it's a great way for anyone, like you're saying, who might be concerned for a young person to really look for these warning signs. So hopefully we'll put that up so that people can—so it looks at things like purposelessness and hopelessness and impulsivity. So it really breaks down some warning signs and symptoms that a young person may be suicidal. But what I always encourage people to do is just to be on the lookout for changes. Oftentimes that can be our best indicator. We don't know which way the changes are always going to come. They might be in behaviors, they might be in emotions.

Ivette:
What sort of behaviors?

Polly:
So, for instance, a young person might in their statement, they might say things like, oh, I don't have to do this project, it's not gonna matter. Or they might start giving away things that are prized possessions or things that usually they used to be really fond of. So there might be some behavioral changes like that that someone should take note of.

Ivette:
And, Polly, that's very interesting and we'll continue that thought when we come back. We'll be right back.

[Music]

Tom Hill:
Suicide, it's such a public health issue in this country. I think it's one of the top ten reasons for death in this country. When people commit suicide, it's not so much that they want to die, they just want to get rid of the pain and they don't see any other way out. So when somebody dies from suicide, their loved ones, friends, families, have a sense of – beyond grief – really feel a sense of depression, despair and this can last for a really really long time if it's not addressed. And a lot of times people don't know why – they feel like they should have gotten over it by now, but still have this lingering sense of despair and hopelessness. And when we look at these folks we really need to address the support they need, they need counseling, they need support groups, they need peer to peer help, they need people who have been there before that can guide them through it, a sense of the fact that they are not alone. That other folks have suffered this tremendous loss and the sense of they don't know why, maybe they feel guilty, they didn't see the signs coming. And to be able to be affirmed that they are not alone and that they can do this together with other people, they can recover.

[Music]

Elizabeth:
I promise you I know what that desperation feels like, I took pills, had my dad's gun. But for whatever reason I am still here. I am a living testimony and to see how my life has turned around and how I'm not only healing from my own wounds but sowing seeds in the lives of others, you have to stick around to get to the other side.

Ashley:
In individuals who have lost their culture or never had their culture, when they add their culture to their treatment plans or add it into their everyday functioning

of life that they find it to be a lot easier. And it's a support system as well and so they have those things to rely on. They have ceremonies, they have prayers and spirituality to rely on to help ground them in their everyday lives and we've seen a lot of improvements when they are participating in sweat lodges and other ceremonies in their mental health status and their physical status as well.

Sierra:
There are a lot of resources out there for a lot of different problems but they are not tied to our culture and you don't really want to separate the two and find a good way to incorporate both and this is perfect for that. So much has happened to native people for so long and it trickles down from generation to generation, it's led to the high rates of alcoholism, high school dropouts, suicide and depression.

Karen:
So with an emphasis of infusing Native American culture and tradition in these trainings we are getting more acceptance.

Sierra:
The biggest most notable skill I have learned is learning about depression and suicide in a cultural way and I feel like now that I have learned a lot about it I would be a lot more effective talking with someone in that kind of situation and in a more understanding, not just an outsider trying to fix someone's issues.

Karen:
I'm seeing a time coming here where the tribes in Michigan can care for their own in a way no one else can care for them. But with the support of programs like this one and then we all learn from each other about how to do this better. It's very very empowering work that we are doing.

[Music]

Male VO:
It takes many hands to build a healthy life. Recovery from mental and substance use disorders is possible with the support of my community. Join the voices for recovery: visible, vocal, valuable!

Female VO:
For confidential information on mental and substance use disorders, including prevention and treatment referral, call 1-800-662-HELP. Brought to you by the U.S. Department of Health and Human Services.

Ivette:
Welcome back. Eileen, Polly was mentioning some resources of SAMSHA and you, in the break, mentioned some others. Do you want to enlighten us?

Eileen:
Yes. So in terms of the warning signs for youth and for adults also, we do have a lifeline wallet card that lists the warning signs that you're talking about.

Ivette:
Why don't you go through them.

Eileen:
Well, there are about eleven of them but the three most important are talking about death or dying, writing about death or dying, and having a plan. So talking about how you would do it. But I think it's very important for parents and anyone else to trust your gut. If you are worried about someone you care about, son, daughter, spouse, friend, ask them. Ask them. I'm worried about you. I'm worried that you're even thinking of suicide. Please talk to me. I can listen to you. Show that you care and hopefully that will help connect them, help them feel less isolated and help them be able to reach out for help. If you need help with that, call LifeLine. They'll coach you through it and then you can refer them to a professional who can help them. Just trust your gut.

Ivette:
Jack, you were talking previously about the vulnerability of those that have attempted suicide.

Jack:
Well, not just attempted suicide but also people exposed to the suicide of someone important to them. There's really pretty compelling evidence now that exposure to suicide increases risk for suicide in the person exposed. People often ask me, you know, my husband killed himself, does this mean my children are at risk? Something like that. Or my sibling did, am I at risk? The answer is on a statistical basis, yes, you're at risk possibility profile has gone up a bit but it's also I want people to understand that there in no way are families doomed if there's been one suicide to have more suicides. It's a little bit analogous to if you had breast cancer running in a family, you would want the women to be educated about what the warning signs are, to be more proactive about monitoring their health and getting regular checkups. I think it's the same when suicide happens in a family is that people need to educate themselves about what contributes to suicide, be a little bit more vigilant but not to be terrified about it.

Amelia:
I would like people to know that it's okay to ask about suicide clearly and directly in the language that's most comfortable to you. Are you thinking about suicide? Are you thinking of killing yourself? Sometimes when people are experiencing this, they're thinking about suicide is that what's happening for you, and to know that they're not planting a seed. That if there's an inkling that there's a feeling there already, that it's okay to address it out in the open, as terrifying as that is. And as Eileen shared, the National Suicide Prevention Lifeline, we've talked with

family members in practice and kind of role played the conversation that they may have with an individual, or to let them know what options they have as far as talking within themselves, sharing our number, calling on a three-way call or having us do a cold call and say someone is concerned about you, they shared that they believe you're suicidal, would you be open to talking with me? And nine out of ten times people will talk with us.

Eileen:
It's a relief to be able to talk about it.

Ivette:
And would the community at large consider these prevention strategies?
Amelia:
I believe so. I've talked with many community members and it's a relief to know that it's okay to talk about. That it's not just for the professionals, that it's not just for the crisis lines, that these are conversations families can have and build a bridge to the mental healthcare providers and to know that there are supports out there for you but the conversation often starts at home and those are the front lines, those are the people that are recognizing….

Jack:
Remember we said at the beginning of this, the biggest cultural barrier to suicide prevention is the taboo about talking about it, and what we're saying is please talk about it. And the Lifeline is not simply for people who are suicidal, it's for people who are worried about someone being suicidal.

Polly:
What we try to talk with families about is just like you would talk with your youth about if they're at a party and someone is drinking. You oftentimes do a rehearsal of that. You do some scripting even with a young person. It's helpful for them to know what to do. This is akin to that so add it amongst those things as teachers, coaches, caregivers, clergy, add it amongst those things that you would say to any young person. You would want them to know what to do if they got in a car with someone who is intoxicated. Tell them what you'd like them to do if they felt suicidal.

Eileen:
And at the beginning when you started us off, you said everyone has a role in suicide prevention. That's absolutely true. So it's not just the clinicians who are out there. It's the community also, and to really prevent suicide we need trained talented clinicians. We need the community to kick in.

Ivette:
And who's training them, Eileen? Where can people go to be trained?

Eileen:
The Suicide Prevention Resource Center has a program called AMSR. They can get training themselves in CBT, DBT.

Ivette:
What is CBT, DBT?

Eileen:
Sorry. Those are the initials that I should've spelled out. Those are the kinds of clinical practices for which there is an evidence base. So clinicians can go online for that. We have at SAMSHA an app called Suicide Safe which is both for primary care physicians and also for behavioral health providers. It teaches you how to do risk assessment, it has case studies, it has resources, patient resources and conversation starters. There are a number of areas where clinicians can get help.

Jack:
There are also programs that have been around a long time and are very effective that help train the general public and caregivers, Assist, QPR. These are programs that train people how to ask correctly and in a safe way someone that you're concerned about being suicidal, and those are available for people to get those trainings.

Ivette:
Very good. So now we come to one of the more interesting parts of the program where I ask you to give me some final thoughts and I'm gonna start with you, Polly. Final thoughts.

Polly:
You know, first of all, I just want to say that it's very important and I appreciate the opportunity to have had this time to talk about this major public health concern and I think Eileen actually said it best in terms of my final thought which is to really listen to your gut and, you know, if you have any type of feeling or any type of concern regardless of who you are, like we said, because oftentimes someone else is going to recognize the warning sign or the symptom, to act on that. And the best way to act on it is to ask the youth. It's a myth to think if you ask them, you're going to implant an idea, you're going to make them suicidal. Ask them. It's okay.

Ivette:
Very good. Jack.

Jack:
Since I'm primarily a grief therapist, grief counselor, I want to say something to people who are bereaved by suicide which is that this can feel like an extraordinarily painful and devastating—not feel like—it is an extraordinarily

devastating and painful experience, but I've worked with enough survivors over the course of my career to understand that people also can heal from it and in fact many people I know who are survivors, who are bereaved by suicide, have gone on to become activists. They now are very engaged in suicide prevention work or reaching out to help other survivors. So there are resources also for people who are bereaved by suicide. The American Foundation for Suicide Prevention has resources, the American Association of Suicidology has resources at their websites.

Ivette:
Very good. Amelia.

Amelia:
I want people to know that it's okay to talk about, it's okay to discuss it, to research information. Too oftentimes we experience a traumatic loss and we don't know where to find ourselves and we don't realize that there are resources available. It is okay to educate yourselves, to seek out information, look at the person as a whole, all of their environmental concerns and know that there's resources, to share those resources with others, start those uncomfortable conversations because they will start to feel comfortable.

Ivette:
Very good. Eileen.

Eileen:
What a great panel. I want people to know that there is hope out there and that things are changing. So there is national action lines for suicide prevention that started in 2010. It is a public private partnership. They are doing amazing work in moving the field forward. SAMSHA has a number of resources. We've talked about Lifeline, the Suicide Prevention Resource Center has one of the best websites out there for pretty much anything you want to know about suicide. We have Garrett Lee Smith Suicide Prevention programs for states, for tribes, for campuses. Go on our website, learn more about it. There are people out there. You are not alone. There is hope, there is help and we're just moving forward.

Ivette:
Very good. Well, we want to thank you for being here, and remind our audience that September is National Recovery Month but actually we celebrate it all year round. You can get more information at recoverymonth.gov and go there to find information on how to develop events, activities where we can continue to talk about substance use disorders and mental health issues that affect our country and to celebrate those that are in recovery. Thank you so much for being here. It's been a great show.

[Music]

Male VO:
To download and watch this program, or other programs in the Road to Recovery series, visit the website at recoverymonth.gov.

[Music]

Female VO:
Every September, ***National Recovery Month*** provides an opportunity for communities like yours to raise awareness of mental and substance use disorders, to highlight the effectiveness of prevention, treatment and recovery services, and show that people can and do recover. In order to help you plan events and activities in commemoration of this year's ***Recovery Month*** observance, the free online ***Recovery Month*** kit offers ideas, materials, and tools for planning, organizing, and realizing an event or outreach campaign that matches your goals and resources. To obtain an electronic copy of this year's ***Recovery Month*** kit and access other free publications and materials on prevention, recovery, and treatment services, visit the ***Recovery Month*** website at recoverymonth.gov, or call 1-800-662-HELP.

[Music]

Male VO:
Your path to recovery isn't like mine.

Female VO:
You have your own struggles with mental health issues.

Male VO:
Your own challenges with substance use disorders.

Female VO:
You also have your own abilities and strengths.

Male VO:
But when you need a hand…

Female VO:
Reach out, until you find one.

Female VO:
For information on mental and substance use disorders, including prevention and treatment referral, call 1-800-662-HELP. Brought to you by the U.S. Department of Health and Human Services.

[Music]

END.